

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08496

8494

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>HENDERSON</u> Last <u>Adkins</u>				4. DATE OF DEATH Month <u>7-</u> Day <u>22-</u> Year <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 23, 1890</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u> Hours <u>19</u> Min. <u>58</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WATKINS PRODUCTS</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES S. ADKINS</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE HENDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-28-4699</u>		17. INFORMANT Address <u>Mrs. W. H. ADKINS BERLIN MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest under anesthesia</u> <u>954x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bleeding duodenal ulcer: severe anemia.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Cardiac arrest while being anesthetized.</u>					
20c. TIME OF INJURY Hour <u>1:08 P.M.</u> Month <u>7-</u> Day <u>22-</u> Year <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pen. Gen. Hosp. Salisbury</u>		20f. (City or town) (County) (State) <u>Wicomico Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		<u>7-22-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOWEN</u>		22d. LOCATION (City, town, or county) (State) <u>NEWARK MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8495

CERTIFICATE OF DEATH

Reg. Dist. No. 88497

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY Accomac			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW CHURCH			
c. LENGTH OF STAY IN 1b 3 Days				d. STREET ADDRESS KELLY'S CAMP			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PRISCILLA Middle ALVARADO Last ALVARADO				4. DATE OF DEATH Month JULY Day 25 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 7, 1956	
9. AGE (In years last birthday) 1 yrs. 10 months 18 days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCISCO ALVARADO				14. MOTHER'S MAIDEN NAME Estetania Nieves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —		17. INFORMANT Estetania Alvarado - new church Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 053.1 Congestive Heart Failure and Pneumonia DUE TO 4 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Staphylococci Septicemia DUE TO 4 days (c) Diarrhea with dehydration (2) Abscesses							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diarrhea with dehydration (2) Abscesses							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-22- , 19 58 , to 7-25- , 19 58 , that I last saw the deceased alive on 7/25/ , 19 58 , and that death occurred at 11:40 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Edgar Wharton Jr. M.D.				ADDRESS (Street, city or town, state) 702 Camden Ave Salisbury Md			
DATE SIGNED 7/26/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-26-58		22c. NAME OF CEMETERY OR CREMATORY R.I.B. Wharton mem.	
22d. LOCATION (City, town, or county) (State) Salisbury, Va.							
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - new church				24a. REC'D BY REGISTRAR JUL 29 '58		24b. REGISTRAR'S SIGNATURE W. J. ...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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1 - MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08498

8496

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>X wetipquin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Rt. 7, D. # 2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Bailey</u> Last <u>Bailey</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>17</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Dashiell</u>		14. MOTHER'S MAIDEN NAME <u>Annie Stewart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-3321</u>	
17. INFORMANT <u>Isola Brown</u> Address <u>1743 N. Carey St Baltimore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interleukary leukemia</u> DUE TO <u>Generalized Osteosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Osteosclerosis</u> DUE TO (c) <u>5 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Neemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 March, 1958</u> , to <u>11 July, 1958</u> , that I last saw the deceased alive on <u>11 July, 1958</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Naticoke Md</u> DATE SIGNED <u>7/11/58</u>			
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.		PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS Naticoke Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		22d. LOCATION (City, town, or county) (State) <u>wetipquin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		ADDRESS <u>Salisbury Md</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Seaton</u>	

MAKLAND STATE DEPARTMENT OF HEALTH - BALTICORE, IS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8497

CERTIFICATE OF DEATH

08499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City 53X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 215 Wicomico Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Prince Middle Edward Last Bass				4. DATE OF DEATH Month July Day 17 Year 19 58			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/27/1904	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Cooking		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Richard Bass				14. MOTHER'S MAIDEN NAME ? Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease, de-compensated DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic varicose ulceration of both legs							
INTERVAL BETWEEN ONSET AND DEATH 5 minutes							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 8 , 19 58 , to July 17 , 19 58 , that I last saw the deceased alive on July 17 , 19 58 , and that death occurred at 1:20 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 7/17/58							
22a. ACTUAL SIGNATURE S. J. Guerman				M.D. Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) V. Guerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 7-21-58		22c. NAME OF CEMETERY OR CREMATORY Rolling Green Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brother M. J. Leach				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 21 '58	
						24b. REGISTRAR'S SIGNATURE W. J. Leach	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8547

CERTIFICATE OF DEATH

Reg. Dist. No.

08500

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lucy</u> First <u>S.</u> Middle <u>Birchett</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-5-02</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Delmar MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Walter Cant.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Nephritis 3 1/2 years</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Generalized Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not-while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 7, 1958</u> to <u>July 9, 1958</u> , that I last saw the deceased alive on <u>July 7, 1958</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Sembley</u> M.D. <u>400 E. Church St.</u>				DATE SIGNED <u>7/10/58</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembley</u>				Salisbury, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockwalling</u>		22d. LOCATION (City, town, or county) (State) <u>Rockwalling MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dorothy M. West</u>				ADDRESS <u>130 2nd St. Salisbury MD</u>		24a. REC'D BY REGISTRAR DATE <u>July 14 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Dorothy M. West</u>							

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>Jan 15, 1920</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Immediate cause: <u>Myocardial Infarction</u></p>		<p>8. Underlying cause: <u>Arteriosclerosis</u></p>	
<p>9. Contributing cause: <u>None</u></p>		<p>10. Manner of death: <u>Natural</u></p>	
<p>11. Signature of physician: <u>[Signature]</u></p>		<p>12. Signature of registrar: <u>[Signature]</u></p>	
<p>13. Date of registration: <u>Jan 16, 1920</u></p>		<p>14. Office of registration: <u>City of Madison</u></p>	

RECEIVED JAN 16 1920

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8498

CERTIFICATE OF DEATH

08501

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital		d. STREET ADDRESS 1 736 Roger St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERTHA Middle MAE Last BOZMAN		4. DATE OF DEATH Month July Day 8 th Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1896
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Lewis Hastings		14. MOTHER'S MAIDEN NAME Martha Ellen Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. N. Granville Bozman (Husband) 736 Roger St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Mesenteric Artery Thromboses Arteriosclerotic Cardiovascular Dis		INTERVAL BETWEEN ONSET AND DEATH 3 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/6 1958, to 7/8 1958, that I last saw the deceased alive on 7/7 1958, and that death occurred at 7:45 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED July 1 / 1958	
ACTUAL SIGNATURE Rufus S. Gardner Jr. M.D.			
PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Jr. Pine Bluff Rd. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 10, 1958	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE JUL 9 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8499

CERTIFICATE OF DEATH

Reg. Dist. No.

08502

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oak Hall Va. 838-3</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>U. S. 13</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Bull</u> Last <u>Bull</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 27, 1976</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Septon of Church</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Septon</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>GEORGE BULL</u>		14. MOTHER'S MAIDEN NAME <u>TABITHA BACON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>229-487940</u>	
17. INFORMANT <u>C. Bull</u> Address <u>Oak Hall Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INGUINAL HERNIA - INCARCERATED (LEFT)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MINS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-30</u> , 19 <u>58</u> , to <u>7-9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-9</u> , 19 <u>58</u> , and that death occurred at <u>11:50</u> A. M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>John M. Bloxom III</u> M.D. <u>Medicaid Center</u> <u>July 10, 1958</u>			
PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM III</u> <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 14, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Douneys</u>		22d. LOCATION (City, town, or county) (State) <u>Oak Hall Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Fox</u> ADDRESS <u>Temperanceville Va.</u>		24a. REC'D BY REGISTRAR <u>Jul 17 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arb. Smith</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
JAMES H. HARRIS		Male		65		1912	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
New York City		Farmer		Heart Disease		Home	
9. COUNTY OF DEATH		10. TOWNSHIP OF DEATH		11. PARISH OF DEATH		12. PRELIMINARY JUDGMENT	
Anne Arundel		Pocomoke		St. James		Natural Causes	
13. NAME OF PHYSICIAN		14. NAME OF MINISTER		15. NAME OF CORONER		16. NAME OF JURY	
Dr. J. H. Smith		Rev. J. H. Smith		J. H. Smith		J. H. Smith	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF MINISTER		19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF JURY		24. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESSES		27. SIGNATURE OF JURY		28. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF WITNESSES		31. SIGNATURE OF JURY		32. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF WITNESSES		35. SIGNATURE OF JURY		36. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESSES		39. SIGNATURE OF JURY		40. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESSES		43. SIGNATURE OF JURY		44. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF WITNESSES		47. SIGNATURE OF JURY		48. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESSES		51. SIGNATURE OF JURY		52. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF WITNESSES		55. SIGNATURE OF JURY		56. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF WITNESSES		59. SIGNATURE OF JURY		60. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF JURY		64. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF WITNESSES		67. SIGNATURE OF JURY		68. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF WITNESSES		71. SIGNATURE OF JURY		72. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESSES		75. SIGNATURE OF JURY		76. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF WITNESSES		79. SIGNATURE OF JURY		80. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESSES		83. SIGNATURE OF JURY		84. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESSES		87. SIGNATURE OF JURY		88. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF WITNESSES		91. SIGNATURE OF JURY		92. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF WITNESSES		95. SIGNATURE OF JURY		96. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESSES		99. SIGNATURE OF JURY		100. SIGNATURE OF CORONER	
		J. H. Smith		J. H. Smith		J. H. Smith	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE BATHING ORD. 78, AND IS NOT VALID FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08503

8500

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>23X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. STREET ADDRESS <u>Commander Hotel</u>	
3. NAME OF DECEASED (Type or print) <u>Annie Butler</u>		4. DATE OF DEATH <u>7-22-1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1903</u> 55 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomack County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Miles</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Drummond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>George Miles, Onancock, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aortic thoracic aneurysm</u> <u>454X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left iliac thrombosis</u> DUE TO (c) _____</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u> <u>24 hours</u></p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <u>7-22-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 27, 1958.</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Joynes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Onancock, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Thomas, Accomack, Virginia.</u>		24a. REC'D BY REGISTRAR <u>Reed Smith</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>JUL 28 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WESTLAND STATE DEPARTMENT OF HEALTH - MEMPHIS, TN
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF TENNESSEE
COUNTY OF _____

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
DATE OF DEATH
PLACE OF BIRTH
PLACE OF DEATH
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH

1. Name of Deceased
2. Age
3. Sex
4. Date of Birth
5. Date of Death
6. Place of Birth
7. Place of Death
8. Occupation
9. Cause of Death
10. Manner of Death

11. Name of Physician
12. Name of Medical Examiner
13. Signature of Medical Examiner
14. Signature of Physician
15. Date of Examination

16. Name of Coroner
17. Name of Juror
18. Name of Juror
19. Name of Juror
20. Name of Juror

21. Name of Juror
22. Name of Juror
23. Name of Juror
24. Name of Juror
25. Name of Juror

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 308 East Church St		d. STREET ADDRESS 308 East Church St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle Butler Jr. Last Butler Jr.		4. DATE OF DEATH Month 7 Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-1957
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 6 Days 26 Hours 26 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Butler, Sr.		14. MOTHER'S MAIDEN NAME Idaree Brand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Samuel Butler, Sr.,		Address 308 East Church St., Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 753.1 DUE TO Epilepsy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Macrocephalust (c) Possible Injury at Birth INTERVAL BETWEEN ONSET AND DEATH 1 day 13 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Chronic Kidney Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury Wicomico Md		20f. (City or town) (County) (State) Salisbury Wicomico Md	
21. I certify that I attended the deceased from January 15, 1958 , to July 24, 1958 , that I last saw the deceased alive on July 23, 1958 , and that death occurred at 5:30 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Herbert G. Sembly		M.D. Salisbury, Md	
PHYSICIAN'S NAME (Type) Dr. Herbert G. Sembly, 400 East Church St., Salisbury, Md.		DATE SIGNED 7/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-25-1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	22d. LOCATION (City, town, or county) (State) Fruitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. T. Stewart Funeral Home, Salisbury, Md		ADDRESS Salisbury, Md	
24a. REC'D BY REGISTRAR JUL 31 '58		24b. REGISTRAR'S SIGNATURE Albeauch	

CERTIFICATE OF DEATH

DECEASED NAME		LAST NAME		FIRST NAME		MIDDLE NAME	
SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS MARRIAGES	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		HOURS		MINUTES		SECONDS	
TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION	
WEIGHT		HEIGHT		HAIR		EYES	
SKIN		TEETH		TONGUE		THROAT	
LUNGS		LIVER		STOMACH		INTESTINES	
KIDNEYS		BLADDER		PROSTATE		VAGINA	
UTERUS		OVARIES		TUBES		PERITONEUM	
PLEURA		PERICARDIUM		HEART		BRAIN	
SPINAL CORD		VERTEBRAL COLUMN		MUSCLES		BONES	
ARTERIES		VEINS		CAPILLARIES		CELLS	
ORGANISMS		TOXINS		ENZYMES		HORMONES	
IMMUNE SYSTEM		CELLS		TISSUES		ORGANS	
SYSTEMS		FUNCTIONS		DYSFUNCTIONS		PATHOLOGIES	
DIAGNOSIS		TREATMENT		PROGNOSIS		FOLLOW-UP	
HISTORICAL		PHYSICAL		LABORATORY		IMAGING	
SURGICAL		MEDICATIONS		THERAPIES		SUPPORTIVE CARE	
NUTRITION		HYDRATION		VITAMINS		MINERALS	
ENVIRONMENT		SOCIAL		PSYCHOLOGICAL		SPIRITUAL	
CULTURAL		ETHNIC		RELIGIOUS		LIFESTYLE	
HABITS		INTERESTS		VALUES		BELIEFS	
ATTITUDES		PERSONALITY		CHARACTER		QUALITIES	
DEFECTS		STRENGTHS		POTENTIAL		ACHIEVEMENTS	
CONTRIBUTIONS		LEGACY		MEMORIES		HERITAGE	
FAMILY		COMMUNITY		COUNTRY		WORLD	
UNIVERSITY		NATION		CIVILIZATION		HUMANITY	
COSMOS		UNIVERSE		GALAXY		COSMOS	
TIME		SPACE		MATTER		ENERGY	
LIFE		DEATH		REBIRTH		CYCLE	
EXISTENCE		MEANING		PURPOSE		SIGNIFICANCE	
IMPACT		INFLUENCE		LEGACY		HERITAGE	
CONTRIBUTION		SERVICE		DEDICATION		SACRIFICE	
COMMITMENT		FAITH		HOPE		CHARITY	
PATIENCE		KINDNESS		GENTLENESS		GOODNESS	
PEACE		LOVE		JOY		HAPPINESS	
CONTENTMENT		SATISFACTION		FULFILLMENT		REALIZATION	
WISDOM		KNOWLEDGE		UNDERSTANDING		INSIGHT	
WISDOM		KNOWLEDGE		UNDERSTANDING		INSIGHT	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08505

8502

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 372 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State H ospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie Middle E. Last Campbell		4. DATE OF DEATH Month July Day 23 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1870
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph M. Croes		14. MOTHER'S MAIDEN NAME Annie Swaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. No	
17. INFORMANT Hospital Records, Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 522X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Arteriosclerotic Cardiovascular Disease; Paralysis agitans		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16 , 19 57 , to July 23 , 19 58 , that I last saw the deceased alive on July 23 , 19 58 , and that death occurred at 4:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 7/24/58			
ACTUAL SIGNATURE G. Kosmahly M.D.			
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/26/58	
22c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS		22d. LOCATION (City, town, or county) (State) BISHOPVILLE Md	
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md.		24a. REC'D BY REGISTRAR 50-28-58 DATE 7/24/58	
24b. REGISTRAR'S SIGNATURE W. J. Seach			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John J. Jones</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1925</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
16. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		17. SIGNATURE OF WITNESSES <i>John J. Jones</i>		18. SIGNATURE OF DECEASED <i>John J. Jones</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8503

Items 4, 9 Film G 231 7/18/58 gr1

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>612 W. Main St.</u>	
3. NAME OF DECEASED (Type or print) <u>Agnes Collins</u>		4. DATE OF DEATH <u>6-7-1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17 - 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Bestie Trader</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior-Septal heart Disease</u> DUE TO (c) <u>ye</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ye</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>
22d. LOCATION (City, town, or county) <u>Salisbury md</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Banker McCreesh</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE JUL 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Adelstein</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5200

STATE OF MARYLAND
DEPARTMENT OF HEALTH

DATE OF DEATH
PLACE OF DEATH

DECEASED

DATE OF
CERTIFICATE

AGE

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

8504

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GUMBORO</u> <u>46x-3</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Penninsula General Hospital</u>		d. STREET ADDRESS <u>WILLARDS, MD. R.F.D.</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>B</u> Last <u>Collins</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 5, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT & FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>NOAH J. COLLINS</u>		14. MOTHER'S MAIDEN NAME <u>DELLA M. COLLINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-34-9525</u>	
17. INFORMANT <u>R. VIRGINIA COLLINS</u>		Address <u>WILLARDS, MD. R.F.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>2 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Renal Shutdown (Uremia)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/14</u> , 19 <u>58</u> , to <u>7/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/14</u> , 19 <u>58</u> , and that death occurred at <u>1:35</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd.</u> DATE SIGNED <u>7/15/58</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>		<u>SALISBURY, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/17/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>WILLARDS, MD. R.F.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>JUL 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 08508

8505

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMACK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>GREENBACKVILLE 83X-3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NEILSON P. COLLINS</u>				4. DATE OF DEATH Month Day Year <u>JULY 29 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 15 - 1892</u>	
9. AGE (In years last birthday) <u>65</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>6/58/14</u>		11. BIRTHPLACE (State or foreign country) <u>Greenbackville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea Food Dealer own business</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food Dealer own business</u>			
13. FATHER'S NAME <u>Peter Collins</u>				14. MOTHER'S MAIDEN NAME <u>Cliah Patten</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes World War I</u>				16. SOCIAL SECURITY NO. <u>230-42-5096</u>		17. INFORMANT Address <u>Mrs Mary A. Collins, Greenbackville, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>S shock</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Peritonitis</u> DUE TO (c) <u>Perforation Colon due to Obstruction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>16 Hrs</u> <u>18 Hrs</u> <u>10 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Greenbackville</u>				20g. (County) <u>Accomack</u>		20h. (State) <u>Virginia</u>	
21. I certify that I attended the deceased from <u>7/26</u> , 19 <u>58</u> , to <u>7/29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/29</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John M. Blokom II</u>						DATE SIGNED <u>7/29/58</u>	
PHYSICIAN'S NAME (Type) <u>JOHN M. BLOKOM II</u>						M.D. <u>MEDICAL CENTER, SALISBURY, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial Aug. 1/58</u>		<u>Aug. 1/58</u>		<u>Greenbackville Cemetery</u>		<u>Greenbackville Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Way E. Hemmis</u>				ADDRESS <u>Shorefield, Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 31 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Hemmis</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use only for burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08510

8506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Dashiields</u>		4. DATE OF DEATH Month <u>7-</u> Day <u>31-</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>G</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/02</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph Dashiield</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Waters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>145-05-0666</u>	
17. INFORMANT <u>Linwood Wilson, Tyaskin, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Newtown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Tyaskin, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Meserich, Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>Al. Leach</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>AUG 5 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - JUNE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2508

100 STATE
HEALTH DEPT

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is partially filled out with handwritten text.

NAME: John Doe
AGE: 45 SEX: M RACE: W
OCCUPATION: Teacher
CAUSE OF DEATH: Heart Disease



CERTIFICATE OF DEATH

Reg. Dist. No.

8548

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Hebron				c. LENGTH OF STAY IN 1b Lifetime			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron (rural)				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES ELDRIDGE DENSON				4. DATE OF DEATH Month July Day 12 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/1876	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months 5 Days 3	IF UNDER 24 HRS. Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Denson				14. MOTHER'S MAIDEN NAME Sallie Street			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----		17. INFORMANT Bessie Mezick Denson, Hebron, Md. R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1958 , to July 12, 1958 , that I last saw the deceased alive on July 12, 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hebron, Md. DATE SIGNED 7/14/58							
ACTUAL SIGNATURE William Emrich M.D.				PHYSICIAN'S NAME (Type) William Emrich Hebron, Maryland 7/14/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/58		22c. NAME OF CEMETERY OR CREMATORY Denson family cem.		22d. LOCATION (City, town, or county) (State) Clara, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. S. Messick				ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR JUL 25 58	
				24b. REGISTRAR'S SIGNATURE W. S. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Age at Death

PLACE TO DEATH		MARRIAGE	
1. PLACE TO WHICH DECEASED WAS TAKEN FOR TREATMENT		2. DATE OF MARRIAGE	
3. NAME OF PHYSICIAN		4. NAME OF SURGEON	
5. NAME OF NURSE		6. NAME OF ASSISTANT	
7. NAME OF CLERK		8. NAME OF ATTENDING PHYSICIAN	
9. NAME OF ASSISTANT		10. NAME OF CLERK	
11. NAME OF ATTENDING PHYSICIAN		12. NAME OF ASSISTANT	
13. NAME OF CLERK		14. NAME OF ATTENDING PHYSICIAN	
15. NAME OF ASSISTANT		16. NAME OF CLERK	
17. NAME OF ATTENDING PHYSICIAN		18. NAME OF ASSISTANT	
19. NAME OF CLERK		20. NAME OF ATTENDING PHYSICIAN	
21. NAME OF ASSISTANT		22. NAME OF CLERK	
23. NAME OF ATTENDING PHYSICIAN		24. NAME OF ASSISTANT	
25. NAME OF CLERK		26. NAME OF ATTENDING PHYSICIAN	
27. NAME OF ASSISTANT		28. NAME OF CLERK	
29. NAME OF ATTENDING PHYSICIAN		30. NAME OF ASSISTANT	
31. NAME OF CLERK		32. NAME OF ATTENDING PHYSICIAN	
33. NAME OF ASSISTANT		34. NAME OF CLERK	
35. NAME OF ATTENDING PHYSICIAN		36. NAME OF ASSISTANT	
37. NAME OF CLERK		38. NAME OF ATTENDING PHYSICIAN	
39. NAME OF ASSISTANT		40. NAME OF CLERK	
41. NAME OF ATTENDING PHYSICIAN		42. NAME OF ASSISTANT	
43. NAME OF CLERK		44. NAME OF ATTENDING PHYSICIAN	
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47. NAME OF ATTENDING PHYSICIAN		48. NAME OF ASSISTANT	
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53. NAME OF ATTENDING PHYSICIAN		54. NAME OF ASSISTANT	
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59. NAME OF ATTENDING PHYSICIAN		60. NAME OF ASSISTANT	
61. NAME OF CLERK		62. NAME OF ATTENDING PHYSICIAN	
63. NAME OF ASSISTANT		64. NAME OF CLERK	
65. NAME OF ATTENDING PHYSICIAN		66. NAME OF ASSISTANT	
67. NAME OF CLERK		68. NAME OF ATTENDING PHYSICIAN	
69. NAME OF ASSISTANT		70. NAME OF CLERK	
71. NAME OF ATTENDING PHYSICIAN		72. NAME OF ASSISTANT	
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75. NAME OF ASSISTANT		76. NAME OF CLERK	
77. NAME OF ATTENDING PHYSICIAN		78. NAME OF ASSISTANT	
79. NAME OF CLERK		80. NAME OF ATTENDING PHYSICIAN	
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83. NAME OF ATTENDING PHYSICIAN		84. NAME OF ASSISTANT	
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87. NAME OF ASSISTANT		88. NAME OF CLERK	
89. NAME OF ATTENDING PHYSICIAN		90. NAME OF ASSISTANT	
91. NAME OF CLERK		92. NAME OF ATTENDING PHYSICIAN	
93. NAME OF ASSISTANT		94. NAME OF CLERK	
95. NAME OF ATTENDING PHYSICIAN		96. NAME OF ASSISTANT	
97. NAME OF CLERK		98. NAME OF ATTENDING PHYSICIAN	
99. NAME OF ASSISTANT		100. NAME OF CLERK	



1. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health of the State of Maryland.

2. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health of the State of Maryland.

3. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health of the State of Maryland.

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10. I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health of the State of Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08512

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Hudson</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bayonne</u> <u>67X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mary Josephine Donovan</u>			4. DATE OF DEATH Month <u>7-</u> Day <u>2-</u> Year <u>19 58</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 26, 1921</u>		9. AGE (In years last birthday) <u>36</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary - U.S. Navy Dept. Depot</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Newark, New Jersey</u>	
13. FATHER'S NAME <u>Martin Davey</u>			14. MOTHER'S MAIDEN NAME <u>Mary Noon</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. William Henry Donovan (Husband)</u> <u>Bayonne New Jersey</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of vomitus</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary atelectasis</u> DUE TO (c) <u>Multiple contusions and lacerations of face and chest.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>2 days</u>
20a. EXTREMAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injured in accident while passenger in front seat.</u>			
20c. TIME OF INJURY Month, Day, Year <u>11:50 a.m. 6-30-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Princess Anne Somerset Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-2-58</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 5, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>East Orange, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Reed Smith</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

STATE AND STATEMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Date of Death: _____

6. Place of Death: _____

7. Cause of Death: _____

8. Manner of Death: _____

9. Signature of Medical Examiner: _____

10. Signature of Coroner: _____

11. Signature of Registrar: _____

12. Signature of Physician: _____

13. Signature of Nurse: _____

14. Signature of Undertaker: _____

15. Signature of Burial: _____

16. Signature of Cremation: _____

17. Signature of Other: _____

18. Signature of Other: _____

19. Signature of Other: _____

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91. Signature of Other: _____

92. Signature of Other: _____

93. Signature of Other: _____

94. Signature of Other: _____

95. Signature of Other: _____

96. Signature of Other: _____

97. Signature of Other: _____

98. Signature of Other: _____

99. Signature of Other: _____

100. Signature of Other: _____

08513

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8549

CERTIFICATE OF DEATH

08514

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs		c. LENGTH OF STAY IN 1b 15 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sadie Middle Maria Last Eversman		4. DATE OF DEATH Month July Day 14 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Donohu		14. MOTHER'S MAIDEN NAME Emily Austin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT J. Ware Eversman, Mardela Springs, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Renal Myocarditis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from _____, 1948, to July 14 , 1958, that I last saw the deceased alive on July 14 , 1958, and that death occurred at 6:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. S. Kuhlman M.D.		ADDRESS (Street, city or town, state) Sharpton Rd	
PHYSICIAN'S NAME (Type) H. S. Kuhlman		DATE SIGNED 7/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-17-58	22c. NAME OF CEMETERY OR CREMATORY Emanuel Methodist	22d. LOCATION (City, town, or county) (State) Mardela Springs, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Marvel, Sharpton, Md.		24a. REC'D BY REGISTRAR Jul 17 '58	24b. REGISTRAR'S SIGNATURE Alfred Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

65-100-54

2000

82-511-7

8509

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BLADES</u> <u>46X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ORA PAGE FLEETWOOD</u>				4. DATE OF DEATH Month Day Year <u>JULY 21 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 16, 1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
13. FATHER'S NAME <u>ISAAC E. ELLIOTT</u>				14. MOTHER'S MAIDEN NAME <u>MARY JANE PRETTYMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>HARRY B FLEETWOOD - BLADES, DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cor Pulmonale, Asthmatic Bronchitis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>July 21</u> , 19 <u>58</u> ; and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Salisbury, Del.</u>				DATE SIGNED <u>July 21, 1958</u>			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.				PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUL 24, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BLADES CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BLADES, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malford L. Watson Jr.</u> ADDRESS <u>SEAFORD DEL.</u>				24a. REC'D BY REGISTRAR <u>JUL 23 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES E. GILBERT		45		M		W		C	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH	
JAN 10 1941		BOSTON		HEART DISEASE		NATURAL		A	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARRIAGE	
JAN 10 1896		BOSTON		HIGH SCHOOL		CLOCK MAKER		MARRIED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		EDUCATION		OCCUPATION		MARRIAGE	
JAN 10 1915		BOSTON		HIGH SCHOOL		CLOCK MAKER		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH	
JAN 10 1941		BOSTON		HEART DISEASE		NATURAL		A	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARRIAGE	
JAN 10 1896		BOSTON		HIGH SCHOOL		CLOCK MAKER		MARRIED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		EDUCATION		OCCUPATION		MARRIAGE	
JAN 10 1915		BOSTON		HIGH SCHOOL		CLOCK MAKER		MARRIED	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

8510 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN lb 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle Virginia Last Gibson		4. DATE OF DEATH Month July Day 12 , Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1894
9. AGE (In years last birthday) yrs. 63		10. IF UNDER 1 YEAR Months 6 Days 3 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Ham & Wife	
11. BIRTHPLACE (State or foreign country) Maryland Cal Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk. John Watson		14. MOTHER'S MAIDEN NAME Mary Nickle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address Salisbury	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Quadriplegia after C.V.A. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days 4 1/2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 30 , 19 58 , to July 12 , 19 58 , that I last saw the deceased alive on July 12 , 19 58 , and that death occurred at 4 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 7-12-58			
ACTUAL SIGNATURE G. Kosmahly		M.D. Dr. Gerhard Kosmahly	
PHYSICIAN'S NAME (Type) Deer's Head State Hospital, Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/15/58	22c. NAME OF CEMETERY OR CREMATORY St. Marks	22d. LOCATION (City, town, or county) (State) Carroll Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. H. H. H. H.		24a. REC'D BY REGISTRAR DATE JUL 15 '58	24b. REGISTRAR'S SIGNATURE W. H. H. H.

VS A15 (4)
15M 10/57

1

8511 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u> 19X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Hall</u> Middle <u>Hall</u> Last <u>Hall</u>		4. DATE OF DEATH <u>July 14 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/13/58</u>
9. AGE (In years lost birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>	11. IF UNDER 24 HRS. Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Hall</u>		14. MOTHER'S MAIDEN NAME <u>Neoma Mason</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Barth Hall</u> Address <u>Princess Anne, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity (1350 gms)</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/13</u> , 19 <u>58</u> , to <u>7/17</u> , 19 <u>58</u> that I last saw the deceased alive on <u>7/14</u> , 19 <u>58</u> , and that death occurred at <u>3:12</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arnell C. Koller</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>7/14/58</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark</u>	22d. LOCATION (City, town or county) (State) <u>Oakville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr. Princess Anne, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JUL 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. James</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar.

CERTIFICATE OF DEATH

Form No. 1

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

DATE OF DEATH

PLACE

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

PERMANENT CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08518

8550

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>		c. LENGTH OF STAY IN lb <u>15 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. R. # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM</u> <u>FRANKLIN</u> <u>HAMILTON</u>		4. DATE OF DEATH Month Day Year <u>July</u> <u>28</u> <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH B. DATE OF BIRTH 9. AGE (In years last birthday) <u>Dec. 27, 1882</u> <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Burton Hamilton</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Spear</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>195-05-7705A</u>	
17. INFORMANT Address <u>Mrs. Sarah J. Anderson, Delmar, Md. R 3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>8 year</u>		INTERVAL BETWEEN ONSET AND DEATH <u>July 27</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 27, 1958</u> , to <u>July 28, 1958</u> , that I last saw the deceased alive on <u>July 27, 1958</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. H. Lynch</u> M.D.		DATE SIGNED <u>Delmar Del July 29/58</u>	
PHYSICIAN'S NAME (Type) <u>S. H. Lynch</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-31-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood</u>		22d. LOCATION (City, town, or county) (State) <u>Harrington, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>(Mrs.) R. H. Boyer, Harrington, Del.</u>		24a. REC'D BY REGISTRAR <u>Aug 7 '58</u>	
ADDRESS <u>Harrington, Del.</u>		24b. REGISTRAR'S SIGNATURE <u>Robert</u>	

1. *Chamaecyparis*
 2. *Juniperus*
 3. *Thuja*
 4. *Podocarpus*
 5. *Sciadopitys*
 6. *Widdowsonia*
 7. *Podocarpus*
 8. *Podocarpus*
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08519

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dalaskbury</u>		c. LENGTH OF STAY IN 1b <u>?</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Dalaskbury Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Hammond</u> Last <u>Hammond</u>				4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-12-14</u>			
9. AGE (In years last birthday) <u>44</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>			
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>Pa</u>		13. FATHER'S NAME <u>?</u>			
14. MOTHER'S MAIDEN NAME <u>Delaskbury John Dept</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Dalaskbury John Dept</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell in river while fishing from bridge</u>					
20c. TIME OF INJURY Month, Day, Year <u>7-20-58</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Forest</u>			
20f. (City or town) <u>Dalaskbury</u>		20g. (County) <u>Wicomico</u>		20h. (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Philip A. Insley</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-21-58</u>			
EXAMINER'S NAME (Type) <u>Phil. P. A. Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE HEREOF <u>7-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>			
22d. LOCATION (City, town, or county) <u>Trumville</u>		22e. (State) <u>Md</u>		24a. REC'D BY REGISTRAR <u>JUL 29 '58</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks W. Chest</u>		24b. REGISTRAR'S SIGNATURE <u>Brooks W. Chest</u>		25. (Signature) <u>Brooks W. Chest</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Baltimore, Maryland 21201

8513 CERTIFICATE OF DEATH

08520

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Nursing Home		d. STREET ADDRESS 1 Pemberton Drive	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Emma Last Hoover		4. DATE OF DEATH Month July Day 7 Year th 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None-House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Timberville, Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Orebaugh		14. MOTHER'S MAIDEN NAME Sarah Hendgardner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk		16. SOCIAL SECURITY NO. Mr. William S. Hoover (Husband) Pemberton Drive. Salisbury, Maryland	
17. INFORMANT Mr. William S. Hoover (Husband) Pemberton Drive. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - in hypertensive heart DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cerebral Hemorrhage (3 attacks) DUE TO Hypertension + Arteriosclerosis (c) Hypertension + Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1958 to July 7, 1958 , that I last saw the deceased alive on 7/7/58 , 19 58 , and that death occurred at 3:10 A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Carrie I. Hearn		ADDRESS (Street, city or town, state) 226 N. Division St. Salisbury, Md. DATE SIGNED July 8 /58	
PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn 226 N. Division St. Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 9, 1958	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Mem. Gardens - Easton, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE JUL 9 '58		24b. REGISTRAR'S SIGNATURE Carrie I. Hearn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "10/15/1900"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]</p>		<p>6. OCCUPATION [Faint text, possibly "Teacher"]</p>	
<p>7. MARITAL STATUS [Faint text, possibly "Married"]</p>		<p>8. DATE OF MARRIAGE [Faint text, possibly "05/10/1925"]</p>	
<p>9. NAME OF SPOUSE [Faint text, possibly "Jane Doe"]</p>		<p>10. DATE OF DEATH [Faint text, possibly "08/10/1945"]</p>	
<p>11. PLACE OF DEATH [Faint text, possibly "Home"]</p>		<p>12. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>	
<p>13. MEDICAL HISTORY [Faint text, possibly "Hypertension"]</p>		<p>14. PRESENT ILLNESS [Faint text, possibly "Stroke"]</p>	
<p>15. SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. J. Smith"]</p>		<p>16. SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]</p>	
<p>17. SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]</p>		<p>18. SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]</p>	

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22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	July 31, '58	Mardela Cemetery (Old)	Mardela, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY		SALISBURY MARYLAND	DATE JUL 30 '58	<i>W. E. Leach</i>

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John William Brown</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10/15/1890</u></p>		<p>4. Place of birth: <u>St. Louis, Mo.</u></p>	
<p>5. Date of death: <u>11/10/1960</u></p>		<p>6. Place of death: <u>St. Louis, Mo.</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Name of informant: <u>John Brown</u></p>		<p>12. Address of informant: <u>123 Main St.</u></p>	
<p>13. Date of completion: <u>11/15/1960</u></p>		<p>14. Registrar's office: <u>St. Louis, Mo.</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8515

CERTIFICATE OF DEATH

Reg. Dist. No.

08522

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELAWARE</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL 46X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>703 7th Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ingersoll</u> Last <u>Ingersoll</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 4, 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>221-09-5163</u>	
17. INFORMANT <u>Stephan P. Ingersoll, LAUREL Del</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery + Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>11</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Glycerative Colitis (in remission)</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 8, 1958</u> to <u>July 8, 1958</u> that I last saw the deceased alive on <u>July 8, 1958</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>July 9, 1958</u>	
ACTUAL SIGNATURE <u>David J. Schure</u> M.D. <u>Salisbury Del</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ODD Fellows Cem</u>		22d. LOCATION (City, town, or county) (State) <u>LAUREL Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>N. J. Shannon Laurel Del.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Schure</u>			

8516 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>AnneArundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u> <u>02X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Rugby Hall</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jackson</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec-15, 1911</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>46</u> Days <u>46</u> Hours <u>46</u> Min.		IF UNDER 24 HRS. Months <u>46</u> Days <u>46</u> Hours <u>46</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William G. Lehr</u>				14. MOTHER'S MAIDEN NAME <u>Ida M. Lehr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>11/11/11</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Albert H. Jackson, Jr.</u>				Address <u>Same As #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO <u>330X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-27</u> , 19 <u>58</u> to <u>7-28</u> , 19 <u>58</u> that I last saw the deceased alive on <u>7-28</u> , 19 <u>58</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilber Ellis, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Baltimore, Md</u> DATE SIGNED <u>7-28-58</u>			
PHYSICIAN'S NAME (Type) <u>WILBER ELLIS, JR. MEDICAL CENTER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 1, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Broughton</u>				ADDRESS <u>Glen Burnie, Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 4 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>Jan 15 1950</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
MARRIAGE <i>Married</i>		OCCUPATION <i>Teacher</i>	
PLACE OF BIRTH <i>Baltimore, Md.</i>		PLACE OF DEATH <i>Baltimore, Md.</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF BURIAL <i>Jan 17 1950</i>		PLACE OF BURIAL <i>St. Mary's Cemetery</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 15 1950</i>		DATE OF SIGNATURE <i>Jan 15 1950</i>	



RECEIVED
JAN 15 1950
BALTIMORE, MD.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 0231 7-25-58 et

8512

CERTIFICATE OF DEATH

08524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 11 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION John B. Parsons Home for Aged				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle Melvin Last Ker				4. DATE OF DEATH Month July Day 17 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1880	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical nurse		10b. KIND OF BUSINESS OR INDUSTRY nursing		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Cannon				14. MOTHER'S MAIDEN NAME Olivia Calloway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT John B. Parsons Home For Aged, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis (c) Cardiac insufficiency							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493 X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7-8 , 19 58 , to 7-18 , 19 58 , that I last saw the deceased alive on 7-18 , 19 58 , and that death occurred at 2 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm B Smith		ADDRESS (Street, city or town, state) Rt. 2, Salisbury, Md.					
PHYSICIAN'S NAME (Type) DR. WILLIAM B. SMITH		DATE SIGNED 7/18/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Delmar, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Robert T. Wallace				24a. REC'D BY REGISTRAR DATE JUL 21 '58		24b. REGISTRAR'S SIGNATURE Rob. T. Wallace	

MEDICAL CERTIFICATION

8518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle ANTHONY Last KLIEM				4. DATE OF DEATH Month 7 Day 15 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1907	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 15 Hours 15 Min.		IF UNDER 24 HRS. Months 5 Days 15 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleman				10b. KIND OF BUSINESS OR INDUSTRY Electrolux		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank J. Kliem				14. MOTHER'S MAIDEN NAME Katherine Bormann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --				16. SOCIAL SECURITY NO. 212-09-0637		17. INFORMANT Address Mrs. Mildred D. Kliem, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 572.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIVERTICULUM DUODENUM DUE TO UNDETERMINED (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 HRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-12 , 19 58 , to 7-15 , 19 58 , that I last saw the deceased alive on 7-15 , 19 58 , and that death occurred at 4:17 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 7/15/58							
ACTUAL SIGNATURE John M. Bloxom M.D.				PHYSICIAN'S NAME (Type) Dr. John M. Bloxom, Medical Center, Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/18/1958		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland ADDRESS Norman T. Baker				24a. REC'D BY REGISTRAR Jul 16 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8519 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 310 Locust Terrace				d. STREET ADDRESS 310 Locust Terrace			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle RAYMOND Last LAYFIELD				4. DATE OF DEATH Month JULY Day 27th Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1881	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 11 Days 7 Hours 7 Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel T. Layfield				14. MOTHER'S MAIDEN NAME Martha Farlow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates at service)		17. INFORMANT Mrs. Ruth M. Layfield (Wife) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-27-58 , to 7-27-58 , that I last saw the deceased alive on 7-27-58 , and that death occurred at 7:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Lee L Lawry Fruitland, Maryland July 28 1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30/58		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUL 30 '58	
24b. REGISTRAR'S SIGNATURE W. F. Educh							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8520

CERTIFICATE OF DEATH

08527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Collins Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Banks Manuel</u>				4. DATE OF DEATH Month Day Year <u>July 17- 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17 1902</u>	
9. AGE (In years last birthday) <u>56 1/2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Manuel</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Rowley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-10-3255</u>		17. INFORMANT <u>Paul Manuel</u> Address <u>2 E. Del.-St. Blue Ave. Painsville N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic nephritis</u> DUE TO (c) <u>Chronic nephritis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/17</u> 19 <u>58</u> , to <u>7/17</u> 19 <u>58</u> , that I last saw the deceased alive on <u>7/17</u> 19 <u>58</u> , and that death occurred at <u>8:45 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul M. Rowley</u> M.D.				ADDRESS (Street, city or town, State) <u>Salisbury Md</u> DATE SIGNED <u>7/17/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Home Beneficial</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Morris</u> ADDRESS <u>Snover Hill Md.</u>				24a. REC'D BY REGISTRAR <u>Jul 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

CERTIFICATE OF DEATH

Form No. 10

DECEASED

DATE OF DEATH

1910

John J. ...

John J. ...

AGE

SEX

John J. ...

John J. ...

CAUSE OF DEATH

HEART DISEASE

1910

John J. ...

John J. ...

John J. ...

John J. ...

John J. ...

LOCAL

REGISTERED

John J. ...

INDEXED

FILED

08528

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

o **DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

o **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Medical Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH o. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. LENGTH OF STAY IN 1b 15 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main St.		d. STREET ADDRESS Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Lloyd McNeal		4. DATE OF DEATH Month 7 Day 21 Year 1958			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH 4-26-1909	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Work		9. AGE (In years last birthday) 49 yrs.		10. BIRTHPLACE (State or foreign country) Maryland	
11. KIND OF BUSINESS OR INDUSTRY invalid		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Daniel Richard McNeal		14. MOTHER'S MAIDEN NAME Marcia Lena Webb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Grason McNeal, Wilmington, Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of brain. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head with gun at home.			
20c. TIME OF INJURY Hour o. m. 4:30 P.M. Month, Day, Year 7-21-58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home.	
20f. (City or town) Pittsville		20g. (County) Wicomico		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-24-58	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/58		22c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery	
22d. LOCATION (City, town, or county) Pittsville, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co., Salisbury, Maryland		ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR JUL 28 '58	
				24b. REGISTRAR'S SIGNATURE Ch. Leach	

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1234

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH

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Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, cause of death, and signature of medical examiner.

1 M 82 I 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 8521 08529 Reg. Dist. No. 1 M 82 I 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8521 08529 Reg. Dist. No. 1 M 82 I 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN TB <u>1 DAY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCINDA PERDUE MITCHELL</u>		4. DATE OF DEATH Month Day Year <u>July 20 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 4, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State and foreign country) <u>POWELLVILLE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN GORDY PERDUE</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ADKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MRS. WILLIAM JARMON, BERLIN MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Cerebrovascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Dis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/19</u> , 19 <u>58</u> , to <u>7/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/19</u> , 19 <u>58</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>PINEBLUFF RD.</u> DATE SIGNED <u>7/20/58</u> ACTUAL SIGNATURE <u>Rufuss S. Gardner, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>RUFUSS S. GARDNER, JR., SALISBURY, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-22-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS</u>		22d. LOCATION (City, town, or county) (State) <u>POWELLVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burboze Berlin Md</u>		24a. REC'D BY REGISTRAR <u>JUL 23 58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8522

CERTIFICATE OF DEATH

Reg. Dist. No. 08530

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
4. DATE OF DEATH First Middle Last Ramon N. Gracia Naverette				4. DATE OF DEATH Month Day Year July 11 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/15/1923	
9. AGE (In years last birthday) 35		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender				10b. KIND OF BUSINESS OR INDUSTRY Bartender			
11. BIRTHPLACE (State or foreign country) Mexico				12. CITIZEN OF WHAT COUNTRY? ?			
13. FATHER'S NAME Guillermo Naverette				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk				16. SOCIAL SECURITY NO.			
17. INFORMANT Deer's Head State Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 days 6 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore, Md.				20g. (County) (State)			
21. I certify that I attended the deceased from June 18 , 19 58 , to July 11 , 19 58 , that I last saw the deceased alive on July 10 , 19 58 , and that death occurred at 2:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital; Salisbury, Md. DATE SIGNED 7/11/58							
ACTUAL SIGNATURE G. Kosmahly M.D.				DATE SIGNED 7/11/58			
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				Deer's Head State Hospital; Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14/58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR DATE JUL 14 '58		24b. REGISTRAR'S SIGNATURE W. J. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8523

CERTIFICATE OF DEATH

Reg. Dist. No. 8531

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHINCOTEAGUE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>147 E KEARSARGE CIRCLE</u>			
3. NAME OF DECEASED (Type or print) First <u>CLYDE</u> Middle <u>WRIGHT</u> Last <u>NEWTON JR.</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9, 1958</u>		9. AGE (In years last birthday) yrs. <u>7</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>SALISBURY, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>CLYDE WRIGHT NEWTON</u>				14. MOTHER'S MAIDEN NAME <u>ANN ROSEMARY BROGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give year or dates of service)</u>		17. INFORMANT <u>Mr. Clyde W. Newton (Father)</u> Address <u>147 E. Kearsarge Circle - Chincoteague, Virginia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO <u>Prematurity (2 lbs - 10 oz)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(2 lbs - 10 oz)</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/9</u> , 19 <u>58</u> , to <u>7/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/11</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>July 11 1958</u>							
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Alfred C. Kolls</u> Medical Center - Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 12, 1958</u>		<u>Wicomico Memorial Park</u>		<u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Beach</u>	

2082341XVI

CERTIFICATE OF DEATH

File No. 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HENRY		M		45		JAN 15 1900		BALTIMORE, MD	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH	
MARRIED		JAN 15 1920		BALTIMORE, MD		JAMES H. HENRY		JAN 15 1900	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
HEART DISEASE		NATURAL		BALTIMORE, MD		JAN 15 1945		10:00 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF SPOUSE	
JAMES H. HENRY		JAMES H. HENRY		JAMES H. HENRY		JAMES H. HENRY		JAMES H. HENRY	
DATE		DATE		DATE		DATE		DATE	
JAN 15 1945		JAN 15 1945		JAN 15 1945		JAN 15 1945		JAN 15 1945	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08532

8524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> x	
c. LENGTH OF STAY IN 1b <u>1 DAY</u>		d. STREET ADDRESS <u>R. F. D. #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JEANNE MARGARET NICHOLSON</u>		4. DATE OF DEATH <u>JULY 16 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 16, 1957</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES L. NICHOLSON</u>		14. MOTHER'S MAIDEN NAME <u>JANE PITCH FORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. James L. Nicholson</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningococic Septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>057.1</u> DUE TO (c) <u>1 day</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-15</u> , 19 <u>58</u> , to <u>7-16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JULY 16</u> , 19 <u>58</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lee L. Lawry</u>		ADDRESS (Street, city or town, state) <u>Fruitland, Md.</u> DATE SIGNED <u>7/16/58</u>	
PHYSICIAN'S NAME (Type) <u>DR. LEE LAWRY</u>		<u>FRUITLAND, MARYLAND</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>7/17/58</u>	<u>WICOMICO MEM. PK</u>	<u>SALISBURY, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Johnson</u>		ADDRESS <u>SALISBURY, MD.</u>	
24a. REC'D BY REGISTRAR <u>Norman F. Baker</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	
DATE <u>JUL 18 '58</u>			

CERTIFICATE OF DEATH

6581

1 day

MARGARET

JAN 16, 1957

12.8

MARGARET

JANE FITCH FORD

JAMES L. NICHOLSON

MARGARET L. NICHOLSON, born

MARGARET L. NICHOLSON, born

JAN 16, 1957

DR. LEE LAWRY FRUITLAND, MARYLAND

born 11/15/20, Baltimore, Md. 12/15/20

11/15/20, Baltimore, Md.

8552 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>			
				f. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>R.</u> Last <u>NUTTER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/84</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>William H. Bradshaw</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Elsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Westley Nutter, Nanticoke, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>28 Aug.</u> , 19 <u>50</u> , to <u>19 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>19 July</u> , 19 <u>58</u> , and that death occurred at <u>9:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.			ADDRESS (Street, city or town, state) <u>Nanticoke Md.</u>		DATE SIGNED <u>7/21/58</u>		
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>			<u>Nanticoke, Maryland</u>		<u>7/21/58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/22/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Bivelve</u>			ADDRESS <u>Bivelve, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 25 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6152

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1952</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>Yes</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
19. SIGNATURE OF CLERK <i>John Doe</i>		20. SIGNATURE OF REGISTRAR <i>John Doe</i>		21. SIGNATURE OF JUDGE <i>John Doe</i>	

RECEIVED JAN 16 1952
BALTIMORE, MD.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

M

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2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08534

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tony Tank Manor		d. STREET ADDRESS Cloverdale Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EUGENE Middle KYLE Last OAKLEY		4. DATE OF DEATH Month JULY Day 19th Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1907
9. AGE (In years for birthday) 51 yrs.		IF UNDER 1 YEAR Months 4 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder (Masonry)		10b. KIND OF BUSINESS OR INDUSTRY Contractor	
11. BIRTHPLACE (State or foreign country) Virginia (Galax)		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Edgar Oakley		14. MOTHER'S MAIDEN NAME Cena Rector	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Viola S. Oakley (Wife) Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio-sclerotic heart disease (c) you DUE TO stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED July 21 / 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1958	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DATE JUL 24 '58	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8526

CERTIFICATE OF DEATH

Reg. Dist. No. 8535

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>P.O.B.# 54</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOIE</u> Middle <u>Perdue</u> Last <u>Perdue</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10:06 P.M.</u> AGE (In years, lost birthday) <u>0</u> months <u>0</u> days <u>0</u> hours <u>14</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Lewis W. Perdue</u>		14. MOTHER'S MAIDEN NAME <u>Ella White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Lewis W. Perdue (Father)</u> Address <u>Parsonsbury, Maryland</u>		P.O.B.# <u>54</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia Neonatorum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature</u> <u>450 gms (5 month gestation)</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>10:29</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.		DATE SIGNED <u>July 17, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William C. Morgan</u>		<u>Medical Center-Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 17, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsonsbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Parsonsbury Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>JUL 21 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>

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CERTIFICATE OF DEATH

20-10-1918

2-11-1918

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2-11-1918

2-11-1918

2-11-1918

6553

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 Spruce Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kate Middle Edna Last Phillips		4. DATE OF DEATH Month July Day 17 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1879
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Sharptown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas W. Walker		14. MOTHER'S MAIDEN NAME Mary Ellen Connely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-18-4346	
17. INFORMANT Edna Ellis, Delmar, Md.		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Hypertensive Carotid Vasculous Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH July 17-48 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1958 to July 17, 1958 , that I last saw the deceased alive on July 17, 1958 , and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE G. H. Lynch		ADDRESS (Street, city or town, state) Delmar, Del	
PHYSICIAN'S NAME (Type) G. H. Lynch		DATE SIGNED July 19-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-20-58	
22c. NAME OF CEMETERY OR CREMATORY Firemans		22d. LOCATION (City, town, or county) (State) Sharptown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Mandy, Sharptown, Md		24a. REC'D BY REGISTRAR DATE JUL 22 '58	
24b. REGISTRAR'S SIGNATURE W. H. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>WORCESTER</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>9 DAYS</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke CITY</i> 2342.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA General Hospital</i>		d. STREET ADDRESS <i>7th STREET</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MAY</i> Middle <i>C.</i> Last <i>PHILLIPS</i>		4. DATE OF DEATH Month <i>JULY</i> Day <i>18</i> Year <i>1958</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 14, 1899</i>
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR: Months <i>5</i> Days <i>8</i> Hours <i>18</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>HENRY C. OUTEN</i>	
14. MOTHER'S MAIDEN NAME <i>MARY F. RITCHIE</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service) <i>—</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>LLOYD J. PHILLIPS, Pocomoke City, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> <i>Coronary Artery Thrombosis</i> DUE TO <i>" Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Thrombosis; Occlusion left popliteal artery</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 9</i> , 19 <i>58</i> , to <i>July 18</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>July 17</i> , 19 <i>58</i> , and that death occurred at <i>7:30</i> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harry J. Schure</i> M.D.		ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>July 18, 1958</i>	
PHYSICIAN'S NAME (Type) <i>Harry J. Schure</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>7-20-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>BAPTIST CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>Pocomoke City, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lenny Watson</i> ADDRESS <i>Pocomoke City, Md.</i>		24a. REC'D BY REGISTRAR <i>—</i> DATE <i>JUL 22 '58</i>	24b. REGISTRAR'S SIGNATURE <i>—</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. WHITE		M		45		JAN 15 1899		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		BALTIMORE, MD	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
OCT 14 1944		10:30 AM		10:30		00		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
J. H. WHITE		J. H. WHITE		J. H. WHITE		J. H. WHITE		J. H. WHITE	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
OCT 14 1944		OCT 14 1944		OCT 14 1944		OCT 14 1944		OCT 14 1944	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8528 CERTIFICATE OF DEATH

Reg. Dist. 8538

1. PLACE OF DEATH a. COUNTY <u>WILCOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANN 19X-2</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>PRINCESS ANN 19X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WINFRIED POWELL</u>				4. DATE OF DEATH Month Day Year <u>JULY 12 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 19, 1891</u> 66 yrs.	
9. AGE (In years last birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James H. Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Emma Bishop</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Arthur Powell Prince</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rt. Breast inoperable</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with gen. metastases</u> DUE TO (c) <u>See 1957</u>		INTERVAL BETWEEN ONSET AND DEATH <u>See 1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>Dec 1957</u> to <u>July 12 1958</u> , that I last saw the deceased alive on <u>July 12 1958</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Med. Center Building, Md.</u> DATE SIGNED <u>7/12/58</u>							
ACTUAL SIGNATURE <u>William B. Long</u> M.D.				PHYSICIAN'S NAME (Type) <u>William B. Long</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marquand Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Wilson</u> ADDRESS <u>Princess Anne Md</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 10

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF CHURCH OFFICIAL</p>		<p>18. SIGNATURE OF FUNERAL HOME</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>20. SIGNATURE OF INTERMENT OFFICIAL</p>	
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<p>99. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>100. SIGNATURE OF INTERMENT OFFICIAL</p>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08539

Reg. Dist. No.

8529

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucille</u> First <u>Long</u> Middle <u>Purnell</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 20, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. B.</u>		13. FATHER'S NAME <u>JOHN I. T. Long</u>	
14. MOTHER'S MAIDEN NAME <u>CORA DISHARON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>R. R. PURNELL, SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic Cerebro-Vascular Disease</u> DUE TO (c) <u>Essential Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>70 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>July 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>58</u> , and that death occurred at <u>8:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>SALISBURY, MARYLAND.</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL, JR.</u>		DATE SIGNED <u>7/11/58</u>	
22a. BURIAL, CREMATION, or other disposal <u>BURIAL</u>		22b. DATE THEREOF <u>7/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson</u>		24. REC'D BY REGISTRAR DATE <u>JUL 15 '58</u>	
ADDRESS <u>Salisbury, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-11-1914
MAY 11 1914
MAY 11 1914

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF MINISTER		12. SIGNATURE OF CORONER	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF CLERK		15. SIGNATURE OF JURY	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF DEPUTY SHERIFF	
19. SIGNATURE OF CONSTABLE		20. SIGNATURE OF TOWNSHIP CLERK		21. SIGNATURE OF COUNTY CLERK	
22. SIGNATURE OF STATE CLERK		23. SIGNATURE OF SECRETARY		24. SIGNATURE OF ASSISTANT SECRETARY	
25. SIGNATURE OF CHIEF CLERK		26. SIGNATURE OF DEPUTY CHIEF CLERK		27. SIGNATURE OF CLERK IN CHARGE	
28. SIGNATURE OF CLERK IN CHARGE		29. SIGNATURE OF CLERK IN CHARGE		30. SIGNATURE OF CLERK IN CHARGE	
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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or reburial, and in any event within 72 hours after death.

82

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08540
Item 5, - See birth certificate of same date										
Item 2 - 8530										
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> <u>23X-2</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>Box 142</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)			First <u>Redden</u> Middle <u>Redden</u> Last <u>Redden</u>			4. DATE OF DEATH			Month <u>July</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 27 1958</u>		9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>27</u> Hours <u>19</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN REDDEN</u>					14. MOTHER'S MAIDEN NAME <u>ETHEL CLARK</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MR. JOHN REDDEN</u> Address <u>OCEAN CITY MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>751X</u> <u>encephaly</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemato Meningo-coele</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>7/27, 1958</u> , to <u>7-27, 1958</u> , that I last saw the deceased alive on <u>7-27, 1958</u> , and that death occurred at <u>8:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>22nd St. Ocean City, Md.</u> DATE SIGNED <u>7/28/58</u>										
ACTUAL SIGNATURE <u>W. H. Smith</u> M.D. <u>W. H. Smith</u>										
PHYSICIAN'S NAME (Type) <u>W. H. Smith</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>7/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>			22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burke</u>						ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>

2082 271XVO

CERTIFICATE OF DEATH

25-50

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		April 14, 1928		Jackson, Mississippi	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
Attorney		Single		Myocardial infarction		Natural		Baltimore, Maryland	
11. DATE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
April 4, 1968		10:15 AM		[Signature]		[Signature]		[Signatures]	
16. MEDICAL HISTORY		17. PRESENT ILLNESS		18. TREATMENT		19. POST-MORTEM EXAMINATION		20. OTHER NOTES	
Hypertension, Diabetes Mellitus		Chest pain, shortness of breath		Nitroglycerin, Aspirin		None		None	

RECEIVED APR 10 1968

8531

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 mos.			
d. NAME OF HOSPITAL (If that in hospital, give street address) OR INSTITUTION 603 Dover Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward Allen Robbins				4. DATE OF DEATH Month July Day 8 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-9-1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Olin K. Robbins		14. MOTHER'S MAIDEN NAME Emory Colonna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-09-2801		17. INFORMANT Address Virginia Carr, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Coronary Cardiac Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertension & Degenerative Heart Disease DUE TO (c) Dissecting Aortic Aneurysm						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Delmar, Del.				20g. (County) Delmar		20h. (State) Del.	
21. I certify that I attended the deceased from Sept 1956 to July 8, 1958 , that I last saw the deceased alive on July 8, 1958 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. H. Lynch M.D.				ADDRESS (Street, city or town, state) Delmar Del.			
PHYSICIAN'S NAME (Type) S. H. Lynch				DATE SIGNED 7-9-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Howell Co - Delmar, Del.				24a. REC'D BY REGISTRAR DATE JUL 14 '58		24b. REGISTRAR'S SIGNATURE Arthur Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1629

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8532 CERTIFICATE OF DEATH

08542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 21 days				d. STREET ADDRESS Route 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle Elwood Last Robbins				4. DATE OF DEATH Month July Day 1 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1871		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bristol, Rhode Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Gayton				14. MOTHER'S MAIDEN NAME Sarah A. Blount Salisbury, Maryland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Henry E. Sweet (Nephew) R.D. # 1 Hospital Records, Deer's Head State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca. of uterus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 10 , 19 58 , to July 1 , 19 58 , that I last saw the deceased alive on July 1 , 19 58 , and that death occurred at 9:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Kosmahly				ADDRESS (Street, city or town, state) Deer's Head State Hospital Salisbury, Maryland		DATE SIGNED 7/1/58	
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				DEER'S HEAD STATE HOSPITAL		7/1/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Swan Lake Cemetery		22d. LOCATION (City, town, or county) (State) Dennisport- Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUL 2 1958	
				24b. REGISTRAR'S SIGNATURE W. H. Search			

CERTIFICATE OF DEATH

Reg. No. 10

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>		<p>3. AGE [Faint text, possibly "45"]</p>	
<p>4. DATE OF DEATH [Faint text, possibly "Jan 15, 1912"]</p>		<p>5. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>6. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>7. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>8. DISEASE OR INJURY [Faint text, possibly "Myocardial Infarction"]</p>		<p>9. MANNER OF DEATH [Faint text, possibly "Natural"]</p>	
<p>10. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>11. SIGNATURE OF REGISTRAR [Faint signature]</p>		<p>12. SIGNATURE OF WITNESS [Faint signature]</p>	
<p>13. NAME OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]</p>		<p>14. NAME OF REGISTRAR [Faint text, possibly "John Doe"]</p>		<p>15. NAME OF WITNESS [Faint text, possibly "Jane Doe"]</p>	
<p>16. ADDRESS OF DECEASED [Faint text, possibly "123 Main St, Baltimore, Md"]</p>		<p>17. ADDRESS OF PHYSICIAN [Faint text, possibly "456 Oak St, Baltimore, Md"]</p>		<p>18. ADDRESS OF REGISTRAR [Faint text, possibly "789 Pine St, Baltimore, Md"]</p>	
<p>19. ADDRESS OF WITNESS [Faint text, possibly "101 Elm St, Baltimore, Md"]</p>		<p>20. DATE OF CERTIFICATE [Faint text, possibly "Jan 15, 1912"]</p>		<p>21. TIME OF CERTIFICATE [Faint text, possibly "10:00 AM"]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08543

8533

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY (in 1b) 23 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Centerville, Maryland 17X-2		d. STREET ADDRESS 105 Halton Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Charles Last Rozier		4. DATE OF DEATH Month July Day 12 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY unk	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Rozier		14. MOTHER'S MAIDEN NAME Laura Chamberlian	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-12-625	
17. INFORMANT Hospital Records, Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with Metastases 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Cardio-vascular disease; DUE TO quadriplegia (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 8 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 19 58 , to July 12, 19 58 , that I last saw the deceased alive on July 12, 19 58 , and that death occurred at 6:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 6/13/58			
ACTUAL SIGNATURE G. Kosmahly M.D.		DATE SIGNED 6/13/58	
PHYSICIAN'S NAME (Type) G. Kosmahly, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery Centerville Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James Butler of Butler Bros. Centerville Maryland		24a. REC'D BY REGISTRAR DATE JUL 17 '58	
24b. REGISTRAR'S SIGNATURE Alfred Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G231 7-11-58 et

CERTIFICATE OF DEATH

08544

Reg. Dist. No.

8534

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico																					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN IB 2yrs6mo27days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury, Maryland																	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Lucy Middle Edith Last Ruark				4. DATE OF DEATH Month July Day 6 Year 19 58																					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26, 1881		9. AGE (In years last birthday) 76 7/8		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA													
13. FATHER'S NAME Frederick Hastings				14. MOTHER'S MAIDEN NAME Mary Frances Taylor																					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. unk		17. INFORMANT Mr. Rollie W. Hastings (Brother) Hospital Records DHSH Salisbury, Md.																			
MEDICAL CERTIFICATION												18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ?				INTERVAL BETWEEN ONSET AND DEATH 5 min.									
												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
												20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																	
21. I certify that I attended the deceased from Dec. 8, 19 55 , to July 6, 19 58 , that I last saw the deceased alive on July 6, 19 58 , and that death occurred at 3:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 7/6/58 ACTUAL SIGNATURE Dr. V. Juerman M.D. PHYSICIAN'S NAME (Type) V. Juerman M.D.																									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 8, 1958		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery				22d. LOCATION (City, town, or county) (State) Salisbury, Maryland															
23. FUNERAL DIRECTOR'S SIGNATURE Hollonay Ho. Salisbury Md.						24a. REC'D BY REGISTRAR DATE JUL 9 '58		24b. REGISTRAR'S SIGNATURE W. Beach																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as in the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08545

18535

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>1 610 CAMDEN AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gertrude CLARK Ryder</u>		4. DATE OF DEATH Month Day Year <u>July 10 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 16, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRACTICAL</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY CLARK</u>		14. MOTHER'S MARDEN NAME <u>MARY TYLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. BLANCHE CAREY, SAME</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO <u>coronary artery thrombosis & myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD Disease</u> (c) <u>ASCVD Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 days</u> <u>Years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/8/58</u> , 19 <u>58</u> , to <u>7/10/58</u> , that I last saw the deceased alive on <u>4-04-10/1958</u> , and that death occurred at <u>4:04 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SALISBURY, MARYLAND</u> DATE SIGNED <u>7/10/58</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>O. J. BURTON 211 MARYLAND AVE SALISBURY, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/14/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill + Johnson, Salisbury, Maryland.</u>		24a. REC'D BY REGISTRAR <u>W. Search</u>	
ADDRESS <u>Norman F. Bakers.</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

8235

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES C. BROWN		MALE		45		JAN 15 1880	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
JAN 20 1925		BALTIMORE, MARYLAND		10:00 AM		101.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1925		JAN 20 1925		JAN 20 1925		JAN 20 1925	



RECEIVED
JAN 21 1925
BALTIMORE, MARYLAND

8554
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FREIDRICH WILHELM SCHMIDT				4. DATE OF DEATH Month Day Year July 17 19 58			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1887	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days 5 25	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-28-4988		17. INFORMANT Address Mrs Edythe Schmidt, Bivalve, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14th 1958 to July 14th 1958 that I last saw the deceased alive on July 14th 1958 , and that death occurred at 2:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Emerich M.D.				ADDRESS (Street, city or town, state) Hebron - Md DATE SIGNED 7/19/58			
PHYSICIAN'S NAME (Type) William Emerich				Hebron, Maryland 7/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/58		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cem.		22d. LOCATION (City, town, or county) (State) Tyaskin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. J. Messink, Bivalve, Maryland				24a. REC'D BY REGISTRAR DATE JUL 25 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8536 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Salisbury, Md. b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4 1/2 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium				d. STREET ADDRESS 1 Ocean City Rd.			
3. NAME OF DECEASED (Type or print) Grant First Middle Last Sexton				4. DATE OF DEATH Month 7-31-58 Day 19 Year 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-3-1868	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY American Fruit	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Jason Sexton		14. MOTHER'S MAIDEN NAME Hester Warner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-01-9426		17. INFORMANT Mrs. Hester S. Redden, Greensboro, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis (c) Brown hypertrophic prostate							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brown hypertrophic prostate							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury, Md.				20g. (County) Wicomico		20h. (State) Md.	
21. I certify that I attended the deceased from 7-29-58 to 7-31-58 , that I last saw the deceased alive on 7-29-58 , and that death occurred at 7:15 P. from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Insley				M.D. Salisbury, Md.			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley				ADDRESS (Street, city or town, state) 116 E. Main St., Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/4/58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Ambler, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				ADDRESS Norman P. Baker		24a. REC'D BY REGISTRAR DATE AUG 8 1958	
24b. REGISTRAR'S SIGNATURE Allen Smith							

8537

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 702 Howard St		e. STREET ADDRESS 702 Howard St	
3. NAME OF DECEASED (Type or print) First ARCHIE Middle WOOD Last SHOCKLEY		4. DATE OF DEATH Month JULY Day 22 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1893
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Bivalve, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Shockley		14. MOTHER'S MAIDEN NAME Hester Webster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. Mr. Carroll S. Shockley (Son)	
17. INFORMANT Salisbury, Maryland		18. ADDRESS 702 Howard St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Vascular Accident DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1958 , to July 22, 1958 , that I last saw the deceased alive on July 22, 1958 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. William B. Smith M.D.		DATE SIGNED July 1958	
PHYSICIAN'S NAME (Type) Dr. William Smith		Medical Center, Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 25, 1958	22c. NAME OF CEMETERY OR CREMATORY Bivalve Cemetery	22d. LOCATION (City, town, or county) (State) Bivalve, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR SALISBURY MARYLAND	
24b. REGISTRAR'S SIGNATURE DATE JUL 24 58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a vital-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8538

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> 23422	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>23422</u>	
3. NAME OF DECEASED (Type or print) <u>Dorothy</u> First <u>Simmons</u> Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9. AGE (In years last birthday) <u>22</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Millington</u>		14. MOTHER'S MAIDEN NAME <u>Dollie Bishop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>411</u>	
17. INFORMANT <u>Helen Collins, 8 A Rodcliffe P.L.</u> Address <u>Charleston S.C.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acidotic Coma</u> 260X DUE TO (b) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>12 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Philip A Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-1-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Presbyterian Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>John's Island, S.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart, West Road Salisbury Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 12 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Krump</u>	

1-2-61

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0238

DATE
TIME



TO BE FILLED OUT BY THE MEDICAL EXAMINER
TO BE FILLED OUT BY THE MEDICAL EXAMINER
TO BE FILLED OUT BY THE MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8539

CERTIFICATE OF DEATH

Reg. Dist. No.

08549

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>DULANEY FARM, POLKS ROAD.</u>			
3. NAME OF DECEASED (Type or print) <u>Lillie Mae</u> First Middle Last <u>STRONG</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14 1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) yrs. <u>3</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert Strong</u>				14. MOTHER'S MAIDEN NAME <u>Idemita Harlin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Aug. 1958</u>		17. INFORMANT <u>Robert Strong Pryor</u> Address <u>Buy 547</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia and Intracranial Hemorrhage</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature - 3 lbs 14 oz</u> DUE TO (c) <u>Congenital Heart Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>July 19 1958</u> , to <u>July 19 1958</u> , that I last saw the deceased alive on <u>July 19 1958</u> , and that death occurred at <u>6:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>7/19/58</u>							
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.				PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>7-20-58</u>		<u>Poke Road Cemetery</u>		<u>Prince Georges</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Wilton</u>				24a. REC'D BY REGISTRAR <u>W. L. Leach</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Leach</u>	
ADDRESS <u>Prince Georges</u>				DATE <u>JUL 23 '58</u>			

4000182XV2

CERTIFICATE OF DEATH

2130

MASS. DEPT. OF HEALTH
BOSTON

CITY

DATE
DECEASED

DATE
DECEASED

PLACE OF DEATH

MASS. DEPT. OF HEALTH
BOSTON

MASS. DEPT. OF HEALTH
BOSTON

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MASS. DEPT. OF HEALTH
BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8540

CERTIFICATE OF DEATH

Reg. Dist. No.

08550

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) Pen Gen. Hospital				d. STREET ADDRESS 509 Liberty St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EDWARD Middle WILLIAM Last TATMAN				4. DATE OF DEATH Month JULY Day 15th Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1911		9. AGE (In years lost birthday) yrs. 47	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman- Ward Baking Co.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mears, Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Littleton Tatman				14. MOTHER'S MAIDEN NAME Lula Carey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.#II				16. SOCIAL SECURITY NO. 220-10-8324			
17. INFORMANT Mrs. Ethel W. Tatman (Wife)				Address 509 Liberty St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 15, 1958 , to July 15, 1958 , that I last saw the deceased alive on July 15, 1958 , and that death occurred at 5:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED July 16/1958							
ACTUAL SIGNATURE Philip A. Insley				M.D. Salisbury, Md.			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley				116 E. Main St. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		July 18, 1958		Spring Hill Memory Gardens - R.D.#		Salisbury, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUL 18 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Reduch			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as a funeral-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8541

CERTIFICATE OF DEATH

Reg. Dist. No. 08551

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bivalve</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eva J. Taylor</u>				4. DATE OF DEATH Month Day Year <u>July 26 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/26/83</u>	
9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas J. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Rose E. Welter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>E21 Taylor, Snow Hill, Md.</u>			
17. INFORMANT Address <u>E21 Taylor, Snow Hill, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 26, 1958</u> , to <u>July 26, 1958</u> , that I last saw the deceased alive on <u>July 26, 1958</u> , and that death occurred at <u>9:40</u> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D. <u>Salisbury, Maryland</u>				<u>7/26/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Treskin, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Messinger, Bivalve, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>AUG 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Messinger</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON, 19

8542

Items 7.9 Film G232 8-18-58 et

CERTIFICATE OF DEATH

08552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Princess Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> 198-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAMIE</u> Middle <u>TAYLOR</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Unknown</u> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Approx. <u>61</u> yrs.	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>David Webster</u>				14. MOTHER'S MAIDEN NAME <u>Leah V. Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Mrs. Norris Dryden Princess Anne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary thrombosis</u> DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Acute Gall Bladder disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>7:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>William H. Fisher</u> M.D.							
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/23/58</u>		<u>Dames Quarter</u>		<u>Dames Quarter Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Harmon Princess Anne</u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUL 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INDIAN AND STATE DEPARTMENT OF HEALTH—BANGALORE, 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8543

CERTIFICATE OF DEATH

08493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>Rourte #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>May</u> Last <u>Waters</u>		4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernie Jones</u>		14. MOTHER'S MAIDEN NAME <u>Betsy Tull</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Oscar Waters, Eden, Md. Rt #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>yes</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-17-58</u> to <u>7-17-58</u> , that I last saw the deceased alive on <u>7-16-58</u> , and that death occurred at <u>1:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7-17-58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Earl L. Royer</u>		407 Camden Ave, Salisbury, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-20-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Eden, Md, Rt #2</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		ADDRESS <u>Funeral Home, Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 18 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Smith</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08553

8544

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna b. COUNTY Philadelphia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia	
c. LENGTH OF STAY IN 1b 2yrs		d. STREET ADDRESS 4112 Barring St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION East Rd. and Morris Sts		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle H. Last Weston		4. DATE OF DEATH Month 7 Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Carrier		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Darlington, S. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emil Weston		14. MOTHER'S MAIDEN NAME Elvira Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 180-16-9648A	
17. INFORMANT Mrs. Paige Glaze, East Rd. & Morris St.		Address Salisbury, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Indefinite DUE TO (c) 7 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7 Dec. 58 to 7 July 58 that I last saw the deceased alive on 7 July 58 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 652 W Main DATE SIGNED 8 July 58			
ACTUAL SIGNATURE E. A. Purnell M.D. 652 W Main			
PHYSICIAN'S NAME (Type) Dr. E. A. Purnell 652 W. Main St., Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-11-1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR JUL 14 58	24b. REGISTRAR'S SIGNATURE W. H. Smith

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a funeral-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8545

CERTIFICATE OF DEATH

08554

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u> 192-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last		4. DATE OF DEATH <u>JULY 25</u> 19 <u>58</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 13, 1958</u>
9. AGE (In years last birthday) yrs. <u>12</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry White</u>		14. MOTHER'S MARRIAGE NAME <u>Esther Tolpman Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Henry White Princess Anne, Md</u>	
17. INFORMANT <u>Henry White Princess Anne, Md</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(13 Days)</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/13</u> , 19 <u>58</u> , to <u>July 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 25</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Koller</u> M.D.		ADDRESS (Street, city or town, state) <u>Medicine Center</u> DATE SIGNED <u>7/25/58</u>	
PHYSICIAN'S NAME (Type) <u>Sullivan, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>College Grove Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James</u> ADDRESS <u>Princess Anne</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred C. Koller</u>			

CERTIFICATE OF DEATH

MINIST AND STATE DEPT. OF HEALTH - BATHING 13

DATE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

PLACE OF DEATH

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DATE OF DEATH

TIME OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8555

CERTIFICATE OF DEATH

Reg. Dist. No. **08494**

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home				d. STREET ADDRESS at Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANK HENRY WILLIAMS				4. DATE OF DEATH Month Day Year JULY 22 nd 19 58					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1887			
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 14 Days 14		IF UNDER 24 HRS. Hours 14 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chicken Grower			10b. KIND OF BUSINESS OR INDUSTRY Chickens		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Isaac H. Williams				14. MOTHER'S MAIDEN NAME Annie McKee Mae Dennis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. Roland C. Williams (Son) Pocomoke, Maryland.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Dis. 3 yrs. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 das.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4/15 , 19 58 to 7/22 , 19 58 , that I last saw the deceased alive on 7/20 , 19 58 , and that death occurred at 8:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pine Bluff Rd. Salisbury, Maryland DATE SIGNED July 7/23/58									
ACTUAL SIGNATURE Rufus S. Gardner Jr. M.D.									
PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Jr				Pine Bluff Rd. Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24/58		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		22d. LOCATION (City, town, or county) (State) Powellville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUL 24 '58		24b. REGISTRAR'S SIGNATURE Arthur	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

8546

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08495

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>438 South Street</u>		
3. NAME OF DECEASED (Type or print) <u>Maggie Williams</u>			4. DATE OF DEATH <u>7-6-58</u> 19 <u>58</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-12</u>		9. AGE (In years last birthday) <u>45</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Joe Simmons</u>			
14. MOTHER'S MAIDEN NAME <u>Georgie Longston</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>244-10-5709</u>		17. INFORMANT <u>Mrs. Hilda Williams, Easton, Md.</u> Address <u>—</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Coronary occlusion-</u> (c) <u>Diabetes mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>24 hours</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-6-58</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>	22d. LOCATION (City, town, or county) <u>Easton</u>	(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dorhill, Easton, Md.</u>		ADDRESS <u>—</u>		24c. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>
DATE <u>JUL 8 '58</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE BOARD OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2025

STATE OF MARYLAND
DEPARTMENT OF HEALTH

DATE OF DEATH
1925

NAME

RESIDENCE

PLACE OF DEATH

CAUSE OF DEATH

DATE OF EXAMINATION
1925

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

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DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8556

CERTIFICATE OF DEATH

08555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland				c. LENGTH OF STAY IN TB allher life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fruitland															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Street				d. STREET ADDRESS Church Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last Henreitta Wright				4. DATE OF DEATH Month Day Year 7 25 1958																			
5. SEX Female		6. COLOR OR RACE AA		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-15-1892		9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Henry Crisfield				14. MOTHER'S MAIDEN NAME Mamie Lankford																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Address Mrs. Mary Hutt, Church St., Fruitland, Md.															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease DUE TO Hypertension (c) Hypertension INTERVAL BETWEEN ONSET AND DEATH 5 months 5 years Week												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. + Salisbury, Wicomico Md				20f. (City or town) (County) (State) Salisbury, Wicomico Md											
21. I certify that I attended the deceased from March 19 52 to July 24 19 58 , that I last saw the deceased alive on July 23 19 58 , and that death occurred at 10:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, State) 400 East Church St., Salisbury, Maryland DATE SIGNED 7/28/58 ACTUAL SIGNATURE H. G. Sembly M.D. PHYSICIAN'S NAME (Type) Dr. Herbert G. Sembly																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-28-1958				22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery				22d. LOCATION (City, town, or county) (State) Fruitland, Maryland											
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. F. Stewart Funeral Home, Salisbury, Md								24a. REC'D BY REGISTRAR DATE JUL 31 '58				24b. REGISTRAR'S SIGNATURE Alfred Smith											

